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NASHVILLE JOURNAL
OF
MEDICINE AND SURGERY

CHARLES S. BRIGGS, A. M., M. D., Editor and Proprietor
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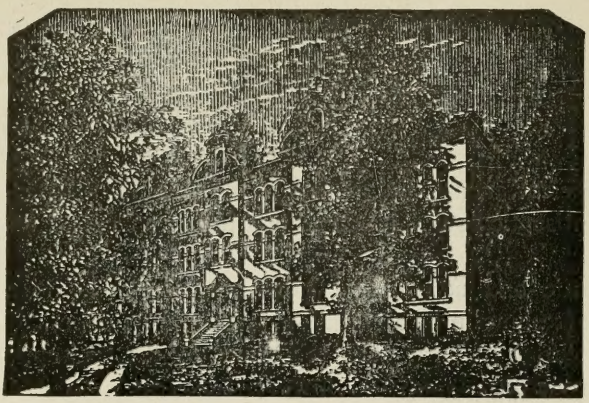

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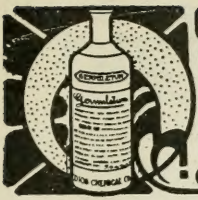

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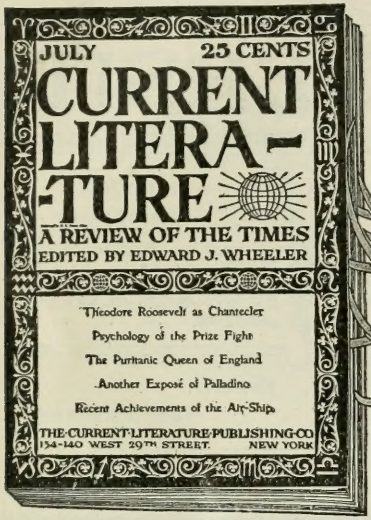
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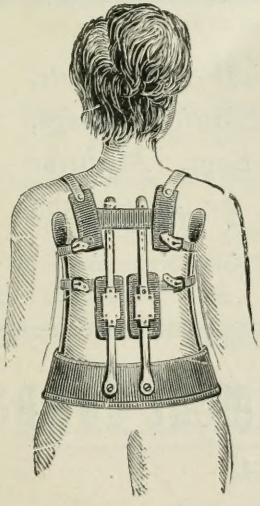

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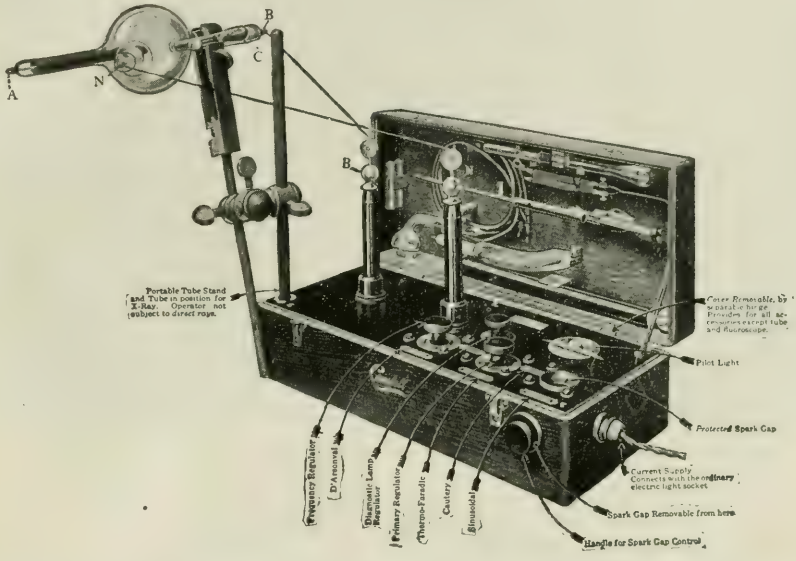

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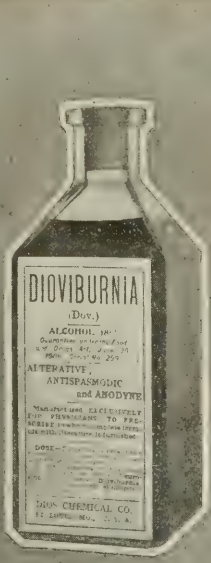

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NASHVILLE JOURNAL
—OF—
MEDICINE AND SURGERY

CHARLES S. BRIGGS, A. M., M. D., Editor

VOL. CVI. JUNE, 1912. No. 6.

Original Communications

REPORT OF CASE. ABDOMINAL CAESEREAN SECTION.*

By CHARLES R. WRIGHT, M.D., Pulaski, Tenn.

An operation of choice, when the life of the child or mother is in danger, by not being able to deliver by the vaginal route.

Unfortunately at the present time, it is usually what it should not be, viz.: an emergency operation.

In our rural location, with no hospital at hand, we must not attempt the sending of such cases to the well-equipped institutions of our distant cities, for, by so doing, we are procrastinating, and the thief of time often carries our patient to the "Silent Beyond."

On the morning of March 14, 1912, at 6:30 a.m., I was called as consultant physician and surgeon in this case.

Case L. F.—White, age 24 years and first child. As a child, she had many diseases common to children. One sister died of dropsy. Two brothers, father and mother are living and in good health. She and her family physician report that during the last few weeks of her pregnancy her feet and legs were swollen well to the knees, and her abdomen well enlarged, which misled her friends and family from thinking she was pregnant. After an examination by me, the family was informed of her condition and medical treatment instituted. She was in convulsions. The

*Read before the Middle Tennessee Medical Association, Pulaski, Tennessee, May 16, 1912.

convulsions continued to increase in frequency and severity—at first about thirty minutes, and in a few hours as often as every fifteen or twenty minutes.

At 10:30 a.m., I decided to try to deliver the child, and called a nurse for the case. The patient was chloroformed and placed on a table in the kitchen. Dilation of the cervix was tried for an hour and forty minutes, but the cervix could be dilated only after much force, and when the fingers were inserted to assist, it would contract down so that I had to go back to instrumental dilation time and again. It was then that the Caeserean section appeared to be the only means by which the life of the mother or child, one or both, might be saved, for the unborn infant continued to give signs of life by movements after a slight convulsion of the mother under the anesthetic.

To do the viginal Caesarean section through a vagina that had not been warned by nature what was to come through it, and no relaxation in any of its parts, would be criminal for the laceration it would cause the mother, and the amount of repair it would necessitate. The abdomen, which had held this pregnant uterus for these many weeks of pregnancy offered me a much better route, and one that could be handled with more ease.

The position of the fetus having been previously made out as correctly as possible, and by knowing this, it was a point of value when I made the uterine incision.

The incision of the abdomen was in the median line, and down to within an inch and a half of the bladder, and about three inches above the umbilicus. The bleeding from the abdominal walls was "nil." As I was making my abdominal incision, through the abdomen, it was done with the utmost care. When the abdominal incision was large enough, I drew the uterus out upon the abdominal walls in order to open it. I packed around it such sterile towels as I had at hand, for fear something might happen which would infect and give trouble. I could not tell how clean the case was, upon which I was operating; therefore, to be on the safe side, I drew the uterus out upon the abdomen. In opening the uterus, two lines of incision presented themselves. One was by a transverse incision over the fundus, parallel to the course of the ovarian blood vessels. The other was a longitudinal in-

cision from the fundus toward the cervix, which in every respect is a classical incision, and was done in this case. The amount of blood lost from the uterine incision was less than two pints.

The position of the child in the uterus governed the way in which it was taken out, i.e., in the vertex presentation, the feet and buttock was the first to come out through the uterine incision. When the child was delivered, I turned it over to my anesthetist, Dr. E. C. Freeman, and had the resuscitation of the child begun. I did not clamp or cut the cord until it had ceased to pulsate. While time is always valuable, the life of the child was considered and given every chance possible.

In the delivery of the placenta, I placed my hand over the fundus of the uterus, and used the Crede's method, "as I do when delivering in normal labor." The separation of the placenta was beautiful to watch. It began at the margins, and little by little, it was separated, and in a few minutes the placenta was placed over to one side, and cut, and tied by the doctor who was recuscitating the child.

Before closing the uterus, I delivered into the vagina a part of my packing which I had decided to use in the uterus, in order to give it something to contract down upon. The packing I used was a three-inch strip of gauze, which had been boiled for a half hour. I began by closing, like to like, from the bottom out, and finished with a Cushing's right angle suture on the uterine incision. The suture material used was No. 2 iodinized catgut.

The abdominal wall was closed by interrupted silkworm gut, in the form of No. 8 figures and silver wire sutures. A drain was left in the lower part of the abdominal incision.

The after treatment was strychnin, morphine, eserin, Fowler-Murphy treatment, and liquid diet for several days. This was practically all that was done for the patient. Only once did the temperature run high, and that was only to 102° on the third day, when there was some evidence of milk in the breast. The nurse placed the babe to breast, and in an hour the temperature was down to 99°.

This operation, coming as an emergency—nothing was in order, and it was in one of our humble homes in which they cook and eat in the same room. The cook table was cleaned up the best

that was possible, but it was not long enough; so by placing an ironing-board on the table, it served as an operating table of proper length. The dining table, about seven feet long, had not been cleaned up since the morning meal, and I had the soiled dishes piled up at one end, as I did not have time and help for shining up the room, as is done in our good hospitals. Desiring to use every care to avoid infection, I boiled towels, pans, instruments and everything used in the operation in one large dishpan for twenty minutes. The abdomen was washed, shaved and painted with an iodine solution, and in about six minutes I had the child out and was waiting on the placenta, as it was separating. In this work I only had the assistance of a physician—Dr. E. C. Freeman, to give the anesthetic, and the help of an excellent nurse to assist in the operation. The time consumed in operation was about twenty-nine minutes.

Mr. President, when I received through Dr. C. A. Abernathy, our excellent secretary of the Tennessee Medical Board of Examiners, your request for this paper, I hesitated for a time as to whether I would undertake to write up the case. But having learned from Escupilapius, our father-precepter, that we should ever be as ready to help our brother physicians, as to relieve the sick and suffering, I offer this paper with some misgivings as to the medico-legal complication that may follow.

I hope that you and the society which you have the honor to preside over may find something of value in the case here presented. While I would have preferred to have sat at the feet of many and to have been taught by those who have attained to distinction through years of successful practice, yet at your invitation I contribute my humble offering for your entertainment.

N. A. R. D. NOTES—THE USE OF ETHICAL PREPARATIONS.

The official preparations of the United States Pharmacopoeia and the National Formulary are deserving of careful and conscientious study by the physician. With an aggregate of some

fifteen hundred such preparations to select from, they should, in reality, constitute the modern medical man's armamentarium in his fight against sickness and disease.

The more these medical agents are used and studied, the better they are liked, for the very simple reason that they are real therapeutic agents, with a definite pharmacological action, and, if properly employed, will always perform a definite service and one to be depended on. In this manner each one becomes a powerful and true weapon upon which the physician can place dependence.

Such service can not be given by any preparation of unknown composition, because, as every physician knows, *if you do not know exactly what a thing is, you can not state definitely what it will do.* It may be inert for the purpose, or it may be extremely mischievous and detrimental. It is like a child playing with fire.

There is a decided stimulus in things medicinal at the present time, hence we are anxious to awaken a more widespread recognition of the basic principles of this rational materia medica, as represented by the medicaments of the United States Pharmacopaeia and National Formulary. By studying the composition, dosage and pharmacological action of these preparations, the medical profession, as represented by the individual practitioner, can rid itself of much of the over confidence in complex mixtures, specialties and nostrums.

Any capable pharmacist can make these preparations, for a trained and expert operator considers it both his duty to make them, and also, his privilege. He is trained to do this work, just as a physician is trained to locate, diagnose and cure disease and sickness.

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The following two preparations are most excellent ones from a therapeutic viewpoint, and a thorough familiarity with them will undoubtedly lead the prescriber to employ them as a first choice in the pharmacological conditions indicated:

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Composition—The Elixir of Sodium Salicylate contains 5 gr. (0.34 gm.) of pure Sodium Salicylate in each fluidram (1 cc.),

in a vehicle of Aromatic Elixir. It is always prepared fresh by the pharmacist when required for use.

Dose.—The average does of this Elixir is 7 fluidram (4 cc.), after meals, and well diluted. A much larger dose than 5 grains of this salt is often to be administered, sometimes as high as 30 grains. This is readily accomplished by prescribing (in the case of 30-grain doses), 240 grains of the Salicylate to each fluidram of the mixture.

Therapeutics.—The chief use of this preparation is in acute rheumatism, acting as an anodyne and antipyretic; it also lessens the liability to cardiac complications and shorts the duration of the attack. It is a powerful diaphoretic and an efficient cholagogue.

Remarks.—Tablets of Sodium Salicylate should receive little favor from the physician, as their action is generally very irritant, unless accompanied by large draughts of water. They are frequently so hard as to resist all action in the secretions of the stomach and intestines.

According to Moule Sodium Salicylate is a specific in acute rheumatism, but it must be used in larger doses at first than those commonly employed; in severe cases, 30 grains every hour.

Sodium Salicylate is incompatible with mineral acids or with any preparation containing such.

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Thymol Iodide is a valuable antiseptic, similar to Iodoform. It has the advantage, however, of being less toxic and practically odorless. It may be used as a dusting powder, in ointment or in a solution of Liquid Petrolatum of about 10 per cent strength.

This chemical possesses, in a mild degree, the antiseptic properties of its component ingredients, Thymol and Iodine. Its action is, as a rule, mild, and its greatest activity is made apparent

in nasal and aural affections requiring mild antiseptics. It also favorably influences the course of many cutaneous affections, wounds and sores.

The principal action of this chemical, however, does not reside in its antiseptic properties, but more especially in its direct effect upon the tissues in granulating surfaces. Pharmacologists have not definitely established its peculiarly beneficial action, but it appears to diminish the secretion of the wounded surface and in this manner affords a less suitable medium for the growth of any germs that may be present.

Proceedings of Societies

CINCINNATI ACADEMY OF MEDICINE.

Meeting of April 8, 1912.

Dr. M. L. Heidingsfeld presented a rare type of skin affection, "cutis atrophica idiopathica." Etiology and treatment are not understood; disease of slow progress and benign in character.

The first regular paper was read by Dr. Harry H. Hines, on "Brain Abscess Following Otitis Media—Operation—Recovery," with presentation of the patient. The case showed the difficulty of diagnosis and the effectiveness of the institution of proper surgical treatment. Dr. Hines is to be congratulated on the result in this case.

The second paper, by Dr. W. D. Hines, on "Surgical Lesions of the Stomach and Duodenum," was then read. Dr. Haines dealt at length with the problem of diagnosis and differential diagnosis, and brought out with emphasis that we may at any time have a compound pathology, or one affecting more than one organ in this region, namely, stomach, duodenum, gall-bladder and pancreas, one or all.

The surgical treatment of gastric ulcer is frequently more permanently curative when the gall-bladder is drained at the same time. Pylorectomy is a justifiable procedure in many cases of old chronic ulcer in patients at or past forty years of age. Resection of a solitary ulcer with posterior drainage is better than drainage alone, except where time is an important element. Exploratory surgery is absolutely justifiable in cases not responding to careful medical supervision. Surgery alone can relieve cancer, and should always be resorted to in all forms of pyloric obstruction. Exploration should be early in cancer age cases that show any suspicion of the disease.

Dr. Souther, in discussion, called attention to the practical impossibility of making a differential diagnosis in upper abdominal

conditions, owing to the fact that a circle four inches in diameter would cover all the pathology of the stomach, duodenum, gall-bladder and pancreas. That in the absence of symptoms specially directed to a single condition or organ the diagnostician is left at sea. Frequently, even after the abdomen is opened, there is difficulty in finding the pathology. Pyloric obstruction means operation. Pylorectomy or partial gastrectomy is more curative than gastroenterostomy, and cited personal experience to justify the grounds.

Dr. E. O. Smith then read his paper on "The Complement Fixation Test in the Cure of Gonorrhea." The essayist held that the test is analogous to the Wassermann test in syphilis, the antigen being obtained from twelve types of gonococcus and is polyvalent in character. The test properly carried out is valuable in obscure cases and late as well as latent or systemic gonorrhea. It is valuable in advice as to matrimony, etc.

In the discussion, Dr. Heidingsfeld said his position was very much that of Dr. Smith, but that he had been unfortunate in getting a bad antigen, and had not had the high percentage of positive reactions quoted by Dr. Smith.

Dr. Berghausen gave a scholarly resume of the present status of the work, and added his personal experience. He held that the test has actual merit when in the hands of an experienced man.

Dr. Nelson said the established procedure had given satisfaction in his and others' hands. A positive reaction is valuable, while a negative reaction carries less weight. The test has been of value only since 1911, and then only in the hands of the expert laboratory man. Much more work will have to be done to put this test on a par with the Wassermann in syphilis as a diagnostic measure.

Dr. S. G. Zinke felt that it had a distinct place as a diagnostic measure in differentiating gonorrhea from other similar forms of urethritis and systemic infection.

Dr. Smith in closing called attention to the fact that its use was only indicated where the diagnosis was not possible by the ordinary means, and as a corroborative test of assurance where matrimony was contemplated.

Dr. James H. Williams presented a rare eye case—cystic degeneration of the conjunctiva—with large cyst at the inner canthus and numerous glands of Krause undergoing cystic degeneration.

Dr. Louis Heyn presented a patient with simple pneumothorax, associated with mitral lesion, and gave varieties, diagnosis and treatment instituted in such cases. Dr. Sidney Lange showed a number of X-ray plates, taken of Dr. Heyn's patient, showing needle in place in process of aspirating the air from pleural cavity.

The first regular paper was then read by Dr. Elizabeth Campbell, on "The Feeding of Children from the Bottle to Puberty." Dr. Campbell discussed in a masterly way many very important elements to be considered in the proper development of the child, its appetite and desires for the most valuable food. She reviewed the work that had been done along the line of quantities of the different foods necessary to give proper nourishment to the child of certain weight, and especially emphasized the importance of vegetables as an element of food. She took the ground with Dr. Irving Fisher, that, in order to have proper assimilation or digestion, a desire or hunger for the good was the important thing. She emphasized the importance of developing an appetite or desire for only the kind of food that was best for the child, and the advantage to be gained by never allowing the child to have at any time or to become acquainted with the taste for any form of undesirable food. She took the ground that this element in feeding was prophylactic in character, and very valuable and important in practice.

There was on display on the several tables meals prepared in a scientific way, containing food of sufficient caloric value to nourish a child of different ages for one day.

Mrs. Gilchrist Strong gave a talk from lantern slides, showing the relative food value of different meats and vegetables that form our ordinary foods. Mrs. Strong gave a clear demonstration of the way in which this branch is being taught at the University, and incidentally gave some valuable information in a

commendable way. Her colored slides were from charts made by the United States Government and other standard authorities on caloric value of foodstuffs, and also the relative fat, protein and carbohydrate value.

Dr. Alfred Friedlander, in discussion, commented on the German, American and French methods of teaching this branch of medicine. He felt that the Academy was under obligations to Dr. Campbell and Mrs. Strong for their very excellent presentation of the subject. Dr. E. W. Mitchell also complimented the essayist of the evening, and said he thought it was time well spent on a very important subject.

Dr. H. K. Dunham then read his paper on "Diagnosis of Pulmonary Tuberculosis, Aided by X-ray Stereoscopic Plates." Dr. Dunham's work along this line stands out as a distinct step forward in this field, and ranks very high. A large number of plates were presented to show the value of the method, and, while as a whole it was not original, it represented a compilation of techniques thought to be best. The work has a definite value from a diagnostic standpoint. Dr. Dunham always checks up the plates with the clinical findings. Especial stress is laid on very light percussion and auscultation.

Dr. Moses Scholtz reported a case of an adult male laborer in whom he found a large piece of bone in the rectum, evidently taken in with his food. It was successfully removed.

Dr. Mark A. Brown reported a case of syphilis with a typical blood picture of pernicious anemia. First count showed 1,102,000 reds, and hemoglobin 30 per cent. Patient was in extreme condition, very weak, cachectic and bedridden. He was given seven injections of cacodylate of iron, half a grain each, and then given 0.3 of salvarsan intravenously. In two weeks after admission blood count shows 2,340,000 reds, and 57 per cent hemoglobin. Patient received second dose salvarsan on April 22, and is still improving.

Dr. Ed Wagner presented some patients to demonstrate the luetin reaction in certain cases of syphilis.

Dr. J. Louis Ransohoff reported in detail a case of unilateral septic infarct of the kidney; operation, drainage, recovery. Dr. Ransohoff gave method of diagnosis, which included urinalysis, cystoscopy, color test, physical examination and pain localization symptoms. Kidney was exposed and operated by Cullen wire method and drained. Several infarcts were found in the kidney as well as pus. Patient made a good recovery.

Dr. Jesse Wyler reported a case with symptoms of epilepsy entirely relieved by refraction and wearing suitable glasses. Dr. Wyler did not believe it to be true epilepsy, but reported the case for what is was worth. Dr. Dandman discussed the case, and said he was glad that such important features of refraction had been brought to the attention of the profession, and cited cases in his practice to bear out the value of proper refraction.

Dr. W. D. Haines reported a case of malignant disease of the testicle. He laid stress upon a number of points to be considered in the differential diagnosis. The finding of sero-sanguineous fluid in the tunica vaginalis is always suspicious of malignancy. Among solid tumors of the testicle, tuberculosis, syphilis and cancer are the most common, and solid benign tumors are rare.

Dr. Charles T. Souther reported a case of multiple cystic degeneration of the great omentum and gastro-colic mesentery involving the transverse colon; resection, recovery. In this case the entire omentum, twelve inches of the transverse colon and the gastro-colic mesentery was removed with the cysts, the mass weighing about six to eight pounds. End-to-end anastomosis of the colon was made. Patient had a smooth convalescence and a clean wound, no drainage being used. One cyst was found in the parietal peritoneum, metastatic in character, and patient will be relieved but not cured. Discussed by Dr. J. A. Johnston, who called attention to the difficulty in making the diagnosis in these

cases, and the necessity of being able to deal with any condition found when the abdomen was opened.

The Academy had the following distinguished visitors present, who made short speeches at the invitation of the President: Dr. O. G. Pfaff, of Indianapolis; Dr. Brayton, of Indianapolis; Dr. A. B. Davis, of New York City; Prof. Charles Richmond Henderson, of Chicago.

Dr. Davis gave a very interesting talk on Cæsarean section, of which he has done one hundred and thirty-four operations. He outlined the indications and described his technique.

Prof. Henderson gave a very eloquent address on special economics. He plead for the full coöperation of the medical profession with workers in sociology, looking toward the enactment of legislation to better man's economic relations.

The Academy then adjourned to enjoy liquid refreshments and cigars.

Dr. W. D. Hines made a motion to have Wassermann reactions made by the Health Department, free of charge, in cases of indigent afflicted. This service to be open to any physician's charity patients, and that the secretary be instructed to notify the Health Department of said action. Dr. Haines suggested further that all requests for test be accompanied by certificates stating that the case in question is really deserving of charity. Carried.

Dr. C. R. Holmes presented a series of twelve mastoid cases that had been operated by the modern blood clot method, and reviewed in detail the relative merits of the old and new methods. He held that the patients recover very much earlier, and the ultimate results as to hearing are much better than formerly. The method is ideal for chronic cases. Primary union can be expected even though a typically radical operation is done. The blood clot may show signs of softening and breaking down, but no effort is made to drain. Special effort is made to preserve the periosteum and to carefully stitch it back in place to cover all of the denuded bone area. Great care is exercised to remove all

diseased tissue. The wound is then sterilized, first by full strength peroxide of hydrogen for three minutes, followed with alcohol 98 per cent for three minutes, then closed by suturing the periosteum with catgut and the skin and muscular separately with silkworm gut. Acute cases are less favorable for this method on account of the higher degree of virulence of the infecting microorganisms, but it is still the most desirable. The technique for acute cases is the same as for chronic cases. In acute cases the wounds frequently become very foul on the fifth to the tenth day, but nothing is done except to change the dressing and mop them clean and in a few days they clear up. Progress is very much more rapid than by the older methods. The patients are saved the pain and long-continued after-dressing formerly required. The method marks a most distinct advance in treating this type of cases.

Dr. E. M. Baehr presented a patient, male, forty-seven, tanner by trade, suffering from muscular atrophy due to paralysis of the suprascapular nerve. The modified use of arm was demonstrated with corresponding infrascapular muscular atrophy.

Dr. W. D. Haines presented a patient with a rupture of the short head of the biceps of the left arm, at the musculo-tendinous portion. It is the third case he has seen. He presented the other two cases to the Academy. No special treatment was advised, as the patient's general musculature and condition did not warrant an anesthetic. Prognosis was very much reduced function for the arm in the future.

Dr. Porter called attention to the delinquent members and the effect it had on the number of delegates to the State meeting. Dr. C. L. Bonifield then made a motion that a committee of three be appointed to arrange for the Academy to have a full representation of delegates at the State society, seconded by Dr. Haines and carried. The president then appointed on that committee Drs. Bonifield, Holmes and Mitchell. Dr. A. G. Drury (treasurer) stated that the probable deficiency would not be great, provided the members responded as well as he expected this week.

The regular paper of the evening was then read by Dr. C. R. Holmes on "Development and Construction of Tuberculosis Sanatoria in Europe and America." Dr. Holmes showed a large number of lantern slides to illustrate the different types of buildings in different countries. He gave Germany first place in their efforts and ability to care for their tubercular cases, and Denmark second. New York City ranks first in this country. The general conclusions were to the effect that the group or colony type of small buildings were the most satisfactory. That the inexpensive cottage was the best. That buildings to accommodate from five to twenty patients was probably the most desirable type. The paper contained a great deal of general interest in hospital construction and represents the expenditure of a great deal of time, money and personal effort on the part of Dr. Holmes to get the most modern ideas on what is best for Cincinnati in hospital construction. The paper will appear in full in *The Lancet-Clinic* at a future time.

The Academy extended a vote of thanks to Dr. Holmes for his most valuable paper.

Selected Articles

THE SIGNIFICANCE OF PAIN IN ABDOMINAL DIAGNOSIS.

I.

From the Surgical Standpoint.

BY JAMES P. WARBASSE, M.D., of Brooklyn, N. Y.

The consideration of abdominal pain from a surgical standpoint demands, first, that an examination shall be made. One of the weaknesses of general practice is the disposition on the part of the practitioner to prescribe for abdominal pains without exposing the abdomen and palpating the naked body. I, personally, am constantly hearing of the horrible results of this neglect, and so, while none of you may be aware of such neglect, I assure you that I have it upon good authority that it does exist.

It is quite essential to differentiate between the voluntary rigidity of the abdominal muscles and the involuntary or protective rigidity. That is something which I shall not take the time to discuss. To make this differentiation comes only from practice, but we are constantly seeing men of inexperience failing to differentiate between a voluntary rigidity (which a patient purposely maintains, either to deceive the examiner or because he is fearful of being hurt) and involuntary rigidity which can not be controlled and which is entirely protective. I shall speak chiefly of colic.

As a matter of fact, colic embraces most of the abdominal pains. Colic is a disease of the peritoneum. I do not know that it is generally described in that sense, but if you will recall the condition in which colic occurs, you will see that it takes place in hollow viscera which are covered by peritoneum. Indeed we have no colic of the tubes outside of the region of the peritoneum. In the upper gall tract, stones lodged in the hepatic ducts and surrounded by liver and connective tissue do not give rise to colic, but when the stones come down and engage in the common duct or the cystic duct, this symptom, which we call gall-stone colic,

develops. Colic in the uterus, colic in the kidney, I conceive as being a peritoneal manifestation. When a stone passing through the ureter has passed the peritoneal region, the colic which characterizes its passage through the peritoneum-covered ureter ceases. Over-distension of the bladder gives rise to a pain which is comparable in every sense to a distension of any of these peritoneum-covered viscera, such as the intestinal colic with which we are familiar. Colic is a pain due to the distension of a viscus covered by peritoneum. It is possible that some of the physiologists present or medical internists may dispute this proposition.

Gastric ulcer I will discuss as the first surgical pain-producing condition. The pain may not necessarily be the prominent symptom. Usually it is referred to the epigastrium, whence it may radiate in various directions, generally toward the left subscapular region. The right subscapular region may be the seat of the reflex pain if the ulcer is at the extreme right side of the stomach. This pain is increased upon taking food. The pain does not come come on immediately after the ingestion of food, but usually about one-half hour; and it seems from a collection of autopsy findings in these cases, that the further away from the cardia the ulcer is located, the later the pain, so that if the ulcer is located near the pyloric end of the stomach, the pain may not begin for two or three hours after the ingestion of food. Epigastric tenderness is usually well marked, and often with rigidity of the recti muscles. This tenderness is definitely localized, as well as the pain, and may be given as characteristic of gastric ulcer.

Vomiting gives relief to this pain. Spasm of the pylorus with its concomitant symptoms may be induced by the presence of the ulcer and give the peculiar pain of spasm of the pylorus. The typical pain develops gradually. It is a burning or boring pain, and often radiates to the back or up into the precordium. It is regullar in its occurrence and may be expected usually to come on with a fixed regularity after the ingestion of food. The patients speak of the pain pretty definitely as coming on with fairly certain regularity after eating. The tenderness is pronounced. It is sharply localized in a small area. Diffuse pain usually speaks against ulcer. Exceptionally it may be an aching or dull pain. It may occur only after some particular articles of diet which a patient finds

disagree with him or after some dietary indiscretion.

Pain which is constant or is present before breakfast is rarely due to gastric ulcer. Pain beginning immediately upon taking food is also rarely due to gastric ulcer. In old ulcers the pain may be absent. A practical contribution to the subject will be found in a paper by Dudley Roberts, published in the *Medical Record* of the 17th of October, 1908.

Pain due to cancer o fthe stomach is variable in its character. It may be absent. There may be only a sense of discomfort after eating which can not be characterized as pain. It is calculated by collecting large series of cases that pain is present in about 85 to 90 per cent of the cases of gastric carcinoma. About one-half of the cases suffer severe pain. It may be continuous with exacerbations after eating, or it may be present only after eating. In some cases it appears only after the ingestion of solids. In pyloric cancer, that is, the cancer which is producing some obstruction to the emptying of the stomach, peristalsis causes the pain of obstruction which is relieved by vomiting. Usually this pain is referred to the epigastric region, occasionally passing through to the back, or in some cases felt only in the back. Absence of tenderness, as you are aware, in cancer of the stomach, is the feature which is generally counted upon to differentiate it from gastric ulcer. Carcinoma of the stomach (the few cases which have been studied) give the symptom of pain quite similar to the pain of cancer of the stomach.

In ulcer of the duodenum, the pain may not occur until three or four or even more hours after the ingestion of food, which means that the pain is felt when the food is poured through the pylorus and enters the duodenum. Because of the slower digestion in the night, a patient who has taken a meal late in the day, may not suffer the pain of ulcer of the duedenum until more than four hours; six to eight hours may elapse. These patients are awakened in the night with the peculiar pain. It seems that the pain may be relieved by again taking light food, which apparently acts as a counter-irritant, as it were, causing a physiologic congestion of the stomach and a relief of the duodenal pain.

The pain due to pancreatic disease has been much studied recently. I would refer you for an admirable discussion of this

subject, to a paper by Dr. H. G. Webster on the pathology and diagnosis of pancreatitis, published in the *New York State Journal of Medicine* (September, 1908), which contains a clear description of the pain of pancreatitis. These cases present a dull pain which occupies the middle of the abdomen (the umbilical and epigastric regions). It may radiate but is usually confined, and in the cases in which there is an acute pancreatitis the pain is constant. A healthy adult suddenly seized with a mid-abdominal pain, should prompt us to suspect acute pancreatitis, and the associated characteristic symptoms may be depended upon to clear up the diagnosis. Jaundice in pancreatic disease with this dull pain is often present and differentiates itself from the jaundice of a biliary disease (common duct obstruction) by the absence of the colic. The head of the pancreas presses the outlet of the common duct and produces a backing up of the bile without the obstruction colic.

In the bile tract, the pains which are encountered are rather characteristic. A valuable diagnostic expedient in this region is to hook the fingers up under the arch of the ribs and it will be observed, if the pain is due to obstructive or inflammatory disease of the bile tract, that the patient will not be able to take a full inspiration. In appendicitis, for example, if that test is tried, the patient will be table to take an inspiration; or, if the pain is due to gastric ulcer, the patient will inspire deeply. In cholelithiasis, the pain is usually not relieved by vomiting, which differentiates that on the other hand from pain of gastric ulcer which is commonly relieved by vomiting. Tenderness over the gall bladder usually indicates inflammation of that organ, but we should bear in mind that tenderness in that region may be due to hydronephrosis, to an inflammatory condition about the pylorus, or to ulcer of the duodenum. No intervals between the attacks of pain point to cholelithiasis. Pain is not usually present in malignant disease of the bile tract or at least is very slight.

In typhoid ulcer the pain usually begins when the ulcer perforates, but there is tenderness so soon as the peritoneum becomes involved. Palpation of the typhoid abdomen will elicit pain when typhoid ulcers are producing an infiltration of the peritoneum. Of course, these ulcers may not perforate, but it is commonly

after such tenderness that perforation takes place; and we find in the histories of cases which have been palpated for pain, that there was usually pain (a distinct evidence of peritoneal infiltration) before the sudden and characteristic pain of perforation of the ulcer occurred.

Of the pain of appendicitis, I shall speak but briefly. As you are aware, it is referred at first to the umbilical region and is associated with the vomiting. It is a colicky pain which gradually migrates the region of the appendix. In chronic appendicitis, the pain may be confusing. Indeed, there may be no pain at all. It may be simply a dull aching or only present when the cecum is distended. The painful sensations and discomforts which are found in chronic appendicitis cover a large range. A sign of some interest, I think, in this connection, is the fact that pain, associated with appendicitis, is usually not directly at McBurney's point. Anatomically the base of the appendix is usually at McBurney's point. If we carefully palpate the region of the pain, we find the most exquisitely tender spot somewhere in the neighborhood of McBurney's point, and if we make a dot on each of these two points, McBurney's point representing the base of the appendix, and the other the point of greatest tenderness, and connect them by a line, that line will represent pretty generally the direction of the appendix. This is commonly a valuable thing to know before we open the abdomen.

The differentiation of the pain of appendicitis from other pains, I may speak of briefly. In tuberculosis of the cecum the pain is a more constant pain without the colicky feature of the oppendicitis. In cancer of the cecum there is apt to be a pain which is colicky in the beginning, representing the symptoms of a moderate degree of obstruction. The intestinal muscularis becoming hypertrophied, forces the intestinal contents through the narrowed lumen, giving rise to colicky pains. Later, there comes a time when the pain becomes that characteristic of acute intestinal obstruction. The pain of ureteral colic must also be differentiated.

The pain of rheumatoid arthritis of the vertebral joints affects the nerves leaving the vertebræ. This condition may produce a hyper-sensitiveness of the abdominal wall which has not infrequently been confused with appendicitis. In all of these

reflex pains, however, the rigidity, which is partly a voluntary rigidity, yields to continuous pressure. It is not spastic like that which characterizes the involuntary protective rigidity. The pain of tabes dorsalis with abdominal crises must also be differentiated.

In herpes zoster of the 11th and 12th dorsal nerves and the 1st and 2nd lumbar nerves, there is a sharp boring pain with an exquisite sensitiveness of the abdominal wall, which must be differentiated from that of a lesion in an underlying organ; but here again continuous pressure causes the rigidity to yield. It has happened that the vesicles which appear in herpes zoster have been mistaken on the third or fourth day for vesicles due to applications to relieve pain.

In perityphlitis the pain is more of a steady discomfort without the colicky features unless an appendicitis is superadded. Appendicular colic produces a pain quite characteristic without the distinct muscular protective rigidity. The rigidity, however, supervenes when infiltration of the appendix or an inflammation or infective condition develops. Intestinal colic, acute enteritis, right pneumonia, abscess of the right ovary, all produce right sided pain which must be differentiated from that of appendicitis.

In acute intestinal obstruction, the pain is a distinctly colicky pain. Here we have a distended viscus with its muscularis attempting to overcome an obstruction. This pain persists so long as the muscularis is attempting to overcome the obstructing condition. When sufficient absorption of toxins has taken place to paralyze the muscularis and to anesthetize to a degree the nerves of the bowel, the pain subsides, even though the bowel be greatly distended. Pain arising from the female generative organs I shall not take time to speak of.

The most striking pain from the urinary organs is that of ureteral calculus, which is violent with reflex pain in the groin, scrotum or labia, and the colicky reflexes which tend to cause vomiting. This pain continues to be excruciating so long as the stone is engaged in the part of the ureter covered by peritoneum. The pain suddenly stops when the stone returns to the pelvis of the kidney or enters the bladder. There is a pain, similar to that arising from urinary obstruction, due to angulation of the ureters; also a pain peculiar to movable kidney in which not only the ure-

ter may become angulated and the passage of urine checked, but in which there is actually an angulation of the blood vessels as well, giving rise to a sudden excruciating pain radiating to the groin and as suddenly subsiding when the angulation is relieved by position or manipulation.

The pain of peritonitis, with which I shall close, is colicky for the reason that peritonitis does not give rise to any considerable pain unless it interferes with the function of some viscus covered by peritoneum. The pain which we observe in peritonitis is the pain which supervenes when the intestine has become paralyzed by infiltration of the muscularis with inflammatory products. Ordinarily, peritonitis itself, gives little or no pain. There is tenderness, to be sure, but the pain of peritonitis is secondary pain which is entirely comparable to the pain of intestinal obstruction. In peritonitis, a certain part of the bowel may become paralyzed, and that part of the bowel acts precisely as a segment of bowel which is the seat of some obstructed condition. Indeed, the symptoms are the same. The bowel is paralyzed; it no longer propels along its contents. Material from above forced into this segment does not pass along. Peristalsis is paralyzed, and the pain in these cases is in the segment of intestine immediately above the bowel which is the seat of paralysis.

II.

From the Medical Standpoint.

BY FRANK BETHEL CROSS, M.D., of Brooklyn, N. Y.

The question that arises in our minds is, just *how much dependence in diagnosis can we place upon the one symptom of pain?* Exceptional diagnosis, brilliant diagnoses are made upon the pain alone. Those of us who were fortunate enough to receive instruction from Dr. Starr, recall his recital of the celebrated case of Dr. Charcot: the boy who was brought to Dr. Charcot in evident ill health, from whom no history was obtained, except that he knew that some time in the night he was awakened by pain in the left thumb. The diagnosis was nocturnal epilepsy, with a distinct aura.

We know that in cases presenting classical pain a definite diagnosis can almost be made upon the pain alone, but it is not the cases presenting classical pain that give trouble; it is the large number of cases presenting atypical pain, like those presenting atypical histories, that are the cases difficult of diagnosis, and without proper diagnosis our treatment is apt to be in error.

It would seem as though abdominal pain could only be depended upon in diagnosis when it can be substantiated, and it is interesting to note that the essayists this evening present that suggestion. That would be necessary because of the great variety of atypical forms of pain.

Pain is suggestive in its location, its mode of onset, its character, severity, duration and tendency to recur. When we are helped out by a case history (an accurate one), palpation, and possibly X-ray examination, a diagnosis under these circumstances becomes probable. As additional aids in diagnosis, we have accompanying symptoms of nausea, vomiting, hematemesis, vertigo, syncope, hematuria and rectal discharges. These all help us greatly. It would seem as though the wisest thing to do, barring that the pain is of "acute surgical disease of the right half of the abdomen," would be to observe the case and make the diagnosis while the case is under observation and treatment, treatment under these circumstances being limited to relief of pain. There seems to be nothing like clinical observation of the case. We base our diagnosis upon observation of the case from day to day and not upon the mere presence of pain or upon the one examination.

As a general thing, it may be said that pains correspond in their location to the organ in which the disease process actually is but we can not lay down any definite law. This is a general principle. There are many exceptions. Local causes may produce general abdominal pain, as evidenced in appendicitis with which we are so familiar. On the other hand, a general abdominal condition can produce local pain. How many times in a case of typhoid does our patient complain of localized abdominal pain?

The most severe abdominal pains are usually due to some grave condition, generally of surgical importance, and I can not lay too much stress upon the advisability under these circumstances of

always having surgical advice. It seems to me that many of the errors that are laid at the doors of medical men could be avoided by having surgical opinion. In the hospitals it is easy to obtain this, and we should certainly in our private practice not deprive ourselves of the aid that we seek in our hospital services.

There has been very little mention to-night of perhaps the most frequent cause of abdominal pain, though it has been referred to indirectly; that is, the condition of constipation, an every-day complaint generally attended with considerable discomfort.

Regarding Dr. Warbasse's theory of peritoneal irritation in abdominal pain characterized by colic, it would seem almost as though he had answered his own proposition when he explained the pathology of intestinal colic, as a tension placed upon the fibres of the muscularis muscosa.

Dr. Cabot, in his recent book on differential diagnosis, which is fresh from the press, lays down briefly general principles to obtain in the consideration of abdominal pain. He says that under ordinary circumstances in the great majority of cases, general abdominal pain will be found to be due to gastro-intestinal conditions. If our patients are women, we must take into consideration at once the posibility of some disturbance in the internal genitalia. In middle life there is a particular predilection to gall bladder disease. If our patients are old men or young girls, summarizing everything, he says that we should always consider the urinary tract. This provides us with a brief working basis.—*Long Island Medical Journal.*

Extracts from Home and Foreign Journals.

SURGICAL

Nephropexy.

The author states that surgical intervention for nephroptosis is based upon the principle that the kidney is not an abdominal organ but that it is outside of the abdominal cavity.

Many cases of loose kidney are due to a fall or a strain, especially in young women. Sometimes it seems due to severe labor. The kidney is the only loose organ, all others seem to be in place. In the early stages of the condition, comparatively few symptoms are produced; they gradually increase in severity, giving rise to disturbances of digestion, flatulency, atony of the colon, etc., and as the kidney becomes looser, twisting occurs, and nephritic colic develops.

The nervous symptoms are the principal signs, besides those mentioned, and these are so diverse and numerous that simply by being on the lookout you will find them. A great many are of a hysterical nature and some are found in neurasthenia. Then we have actual pains, and reflex headaches and even insanities of various kinds, and here comes in the fine diagnostician.

The other class of cases where there is a general relaxed condition of the abdominal organs, and also of the kidney, have similar symptoms, aggravated if anything. Placing such a patient on the back, the loose kidney is easily found, but the condition of the abdominal viscera is overlooked; fixation of the kidney is made and the patient not cured.

In case of general abdominal ptosis, the kidney should be fixed first and then the other treatment instituted to cure the patient.

Fixation by the fibrous capsule is permanent. An incision is made at the convex border, from one pole to another, the capsule stripped off on one side and torn towards the pelvis of the kidney. The same procedure is then carried out on the other end of the kidney. The resulting incision is like the letter "Z." The

upper flap is sutured to the erector spina muscle. The lower flap is sutured to the quadratus lumborum at the lower angle of the wound.

The author concludes that:

1. The kidney is not an abdominal organ.

2. The movable kidney produces in many cases great distress and the most diverse symptoms.—*The Post-Graduate.*

A Nephrectomy on a Woman Six Months Pregnant, No Interference With Pregnancy.

Mrs. W. H. H., a white woman, age 22, was admitted to Ward 50, October 27, 1911, with a temperature of 104°, showing all the signs of some thorough intoxication. She was very much depressed and stupid, and unable to give a connected history. The blood was examined, but showed nothing of any importance. No Widal reaction or plasmodium; she loowed so typical of typhoid, however, that she was treated for that trouble. On examination it was found that she was about six months pregnant. The urine showed pus, casts and albumin.

On October 30 she showed some signs of abortion and was moved to ward 48. There she was carefully watched and treated systematically. The pains and hemorrhage left her, but she still remained profusely septic and looked as though she could stand a very little more. As she complained of pain on right side, the ureters were catheterized and the urine from the right side showed pus flowing and then clear urine with another spurt of pus, followed again by urine, this to continue as long as the catheter remains in situ. On the left side the urine was normal. As she continued to grow worse it was decided to expose the right kidney and see if something could not be done to help her. She was prepared, brought to the amphitheater, and, under a general anesthetic, the kidney was quickly exposed through the lumbar incision and brought to the surface, where it was found to be studded with small tubercular abscesses, and in such a condition that nothing but total removal seemed justified. This was done quick-

ly and the patient returned to the ward. The temperature dropped to normal and continued there with the patient improving generally, until about the 20th of November, when she had a rise of temperature, and a cystoscopic examination showed pus still coming from the side from which the kidney was removed, due, I suppose, to the fact that the ligature cut through the ureter and the pus flowed through this patulous channel into the bladder. The wound in the back was washed out carefully and a larger drain inserted, and she has improved rapidly since, all pus having disappeared.

It was necessary to give her hypodermoclysis for weeks, and this caused several abscesses, which were incised and drained.

She is up and about now, and has shown no more symptoms of abortion, and looks as though she might, from present indications, carry the full nine months—*New Orleans Med. and Surg. Journal.*

Tincture of Iodine in Surgery

Reclus praises most fervently the routine use of tincture of iodine in surgery. He compares the elaborate method of treating a contused or lacerated wound of the hand by scrubbing and washing with various applications, all taking up much time, with the simplicity of the iodine treatment. Compresses wet with tincture of iodine are applied to the wound and the surrounding skin is painted over. The whole proceeding only occupies a few minutes. Fresh dressings are applied daily so long as discharge continues. Then a dressing every third or fifth day is all that is necessary. Crusts or coatings over the wound are washed away with peroxide of hydrogen. The pain involved is not of consequence. Reclus tried the method on himself and found that the burning feeling first produced soon passes away. He has not used iodine for extensive burns, but one of his colleagues has done so most successfully in most extensive lesions. Some skins blister after use of iodine, but Reclus has only observed three cases after using the method for a year in his large hospital experience. Even these cases quickly got over the irritation. The caustic properties of old prepa-

rations have been set down to hydriodic acid. Tincture of iodine is not a stable compound and soon decomposes, hydriodic acid being formed. Another cause is that age increases the strength of the iodine as the spirit evaporates by degrees. It is therefore important to use a freshly made tincture or to add to the preparation, if it is to be kept, iodide of potassium in the proportion of gr. xv. to the ounce. Suppurating wounds do very well under this treatment. Cellulitis seems to be prevented from spreading. Reclus recommends that all crushes of the extremities should thus be treated and reports excellent results in compound fractures. He quotes a case of very extensive spreading gangrene involving the belly walls, thorax, and axillæ, in which recovery followed a thorough application of iodine.—(*La Press Medicale*).—(*The Practitioner,* Nov., 1911).—*Pacific Medical Journal.*

Surgical Use of Picric Acid.

Dr. A. Ehrenfreid (*Bulletin Therapeutique,* January 23, 1912), finds that an aqueous solution of picric acid, ½ per cent, destroys in half an hour virulent microbes, and is 50 times stronger in bactericidal action than a 1 per cent solution of phenol. Picric acid was employed in more than 300 cases of burns of the first, second and third degree in children and adults, on recent wounds, and ulcers, with satisfactory results, and in no case were yellow colorations of the integuments or of the urine observed after external application. The best solution for general use is ½ of 1 per cent of picric acid, which can be prepared by dissolving the crystalline picric acid in boiling water. The solution is used by impregnating tampons of gauze with the solution; for the burns of the extremities, immersion of the parts in the solution was employed and then covered with gauze moistened with the solution. For burns of first and second degree and in superficial lesions, the picric acid solution, according to this authority, is superior to all other anticeptic dressings. Extensive burns of the third degree are not amenable to this treatment.—*La Tribune Medicale.*

Malignant Disease of the Testicles.

Mr. H. Morriston Davies (*Lancet,* Feb. 17, 1912), from a study of this subject and his own experience, presents the following summary: 1. All tumors of the testicle must be regarded as malignant. 2. The history of previous venereal disease, the association of the swelling of the testicle with an injury, the length of the history dating perhaps from childhood, must not be allowed to outweigh clinical evidence. 3. Always suspect a tumor of the testicles when there is an oval swelling which is not translucent and comparatively painless. 4. When the tumor is in addition soft or elastic, and the surface shows slight lobulations, regard the suspicions as confirmed. 5. Increased pulsation of the cord is is in favor of tumor, but is not pathognomonic. 6. A solid tumor may be so elastic as to give the feel of a fluid swelling. 7. The aberrant clinical manifestations of a testicular neoplasm must be constantly borne in mind. 8. If the diagnosis is uncertain and the possibility of a growth is entertained the tumor must be explored. Should the tumor be syphilitic, no harm will have been done; if tubercular or a hematoma, operation is the correct treatment. 9. When the diagnosis of tumor is confirmed the complete radical operation, consisting of removal of testicle, cord, lymphatics, and surrounding fascia, and of the lymphatic glands in the region of the aorta and vena cava, must be done, unless the lumbar glands are extensively involved, or there are evidences of metastases elsewhere.—*International Journal of Surgery.*

Skin Disinfection and Surgical Asepsis.

Dr. Gustavus M. Blech (*St. Louis Medical Review,* March), concludes, in the light of his experience with iodine as a skin disinfectant, that the Grossich method is far from being an ideal one, since it has failed to prevent stitch abscesses in clean appendectomies, extirpation of tumors and goiter. He has had far better results with the use of much green soap and very little hot water, followed by rinsing with alcohol.

The author believes "that there is no golden rod of ease to the goal of asepsis, that no one chemical can aid us to achieve that

result, the general care in preparation and minutiæ should not be relaxed for one moment, that it is unscientific, irrational and dangerous to 'destroy' actual dirt on the operative field by mere dry shaving and painting twice in a few minutes with the germ-killer (?) iodine in alcoholic solution."—*The Am. Journal of Clin. Med.*

Epididymitis, Treatment of Gonorrheal.

When a gonorrheal patient complains of tenderness over the point where the cord passes through the external ring, he should be ordered to bed at once and the scrotum supported by a broad strip of adhesive stretched over the anterior surfaces of the thighs Many an attack of epididymitis may thus be avoided, the vasitis which is the cause of the tenderness mentioned then subsiding.

Epididymitis ensues a day or two after the onset of vasitis. The scrotum should here likewise be supported upon the adhesive plaster bridge. Poultices applied to the scrotum give marked relief, but ice applications are to be avoided, as gangrene may follow their use. The following ointment, to be smeared on a cloth and applied to the scrotum, has given the author good results:

℞ Mentholis, gr. xv (1 Gm.).
Ung. belladonnæ, gr. xx (1.3 Gm.).
Ung. Crede, gr. xxx (2 Gm.).
Ichthyolis, ʒj (4 Gm.).
Petrolati, q. s. ad ℥j (32 Gm.).—M.

The swelling subsides in about ten days, often leaving an indurated nodule of the size of a pea at the lower or upper pole of the epididymis. Although this nodule does no harm, unless it is so located as to obstruct the orifice of the vas, it is often a source of anxiety to the patient. It may gradually disappear, but in case it persists and the patient desires its removal the scrotum may be opened and a criss-cross incision of the tunica albuginea made over it. This maneuver is almost invariably successful.

If the swelling of the epididymis does not quickly resolve, the testicle should be strapped, as follows: Envelop the affected half of the scrotum in a square of gauze. Encircle the upper pole of the testicle with the thumb and index fingers, pressing the testicle

into the bottom of the scrotum, and bind a strip of adhesive above the organ so tightly that it can not slip through. Starting at this so-called "choker" strips of adhesive around under the testicle to the opposite side of the choker until the entire organ is covered, then apply a second choker over the ends of the strips. When strapped, the size of the testicle rapidly diminishes, necessitating the renewal of the strapping every second day. The strapped testicle should be supported by a suspensory.—C. W. Bethune (*Buffalo Medical Journal,* November, 1911).

Appendicitis as a Borderland Disease.

Krogius writes in the interest of harmony between physician and surgeon in respect to the choice of treatment of appendicitis. Himself a surgeon, he appears to find a ready way out of the dilemma without prejudice to either side. There is a benign appendicitis which is regular in course and shows no evidence of unfavorable progress, but instead the tendency is always to betterment. When the symptoms persist without tendency to improve the condition becomes a surgical one; and much more so is this the case where the evidence, however slight it may seem, shows a tendency to aggravation. Even a single symptom, become ever so little worse, indicates early operation. The prognosis is by so much graver, and need of intervention the more urgent when any one symptom becomes greatly aggravated, or when several unfavorable sysptoms coexist. If after one attack resolution does not take place within reasonable time, when pain returns and does not abate again, or when a second attack of vomiting or a second chill occurs or when there is only persistent tenderness to pressure without tendency to lessen, it is as good as a diagnosis of impending gangrene or perforation and operation should not be deferred a day. No time should be lost through the palliative use of morphine. If the pain is severe enough for that, the condition is serious enough for operation. The author has now made use of these principles for seven years with a material of hundreds of cases, and in not one has his judgment been misplaced. If the conditions are balanced so evenly that a choice is impossible, one must operate, of course.—*Medical Record.*

MEDICAL

Mouse Tumors and Selenium.

That chemo-therapy, as elaborated by Paul Ehrlich, would continue to develop in other fields than in diseases caused by spirochetes has been doubted only by the worst pessimists. The scientific principles underlying the discovery of salvarsan should show the way to find other similar remedies. Following this trail Dr. Wassermann and his co-workers appear to have made a remarkable observation that "mouse tumors" were favorably influenced by a combination of selenium and eosin. This remedy "has a selective action for the cancerous mass," and caused its liquefaction after three injections. Of course, the discovery has not yet reached the stage when it is available as a remedy for cancer, but is now being studied with the view of finding a preparation free from toxic effect yet possessing the virtues of selenium. Many of the mice treated died, but some lived and appeared to be cured. With such able men working to find a suitable chemical combination—free from deleterious effects—we may at least wish them success. Nothing yet has been done which can be utilized in the treatment of cancer. Unfortunately, the lay press has given much space to sensational and unwarranted reports. Soon quacks and vampires will be preying upon the gullible public with fake remedies purporting to be Wassermann's discovery.—*Journal-Record of Medicine.*

The Musical Memory and Its Derangements (Amusia).

J. Leonard Corning, New York, presents a resume of the psychology of the musical memory, describes the localization of this faculty in the vicinity of the speech centers, and reports illustrative cases showing how lesions of the cerebral tracts causing aphasia, alexia, and agraphia may be accompanied by a loss of musical memory in its various aspects. The musical faculty is developed very early, tone images being formed before word images. Memory is not a simple faculty, but there are many differ-

ent kinds of memory, such as sound and other sense memories, word memories, motor memories, sensory memories, etc. The musical memory includes auditory, visual, and motor memories. The sense of time, rhythm, melody, and harmony are equally important. Musical memory, then, is not a simple matter. The player of instrumental music has much more to learn than the vocalist, since the process of memory is here much more complex. Memory varies very greatly in different individuals as to its constituents and action. With some the auditory memory is much better than the motor memory. Some remember the printed notes, others the sounds and harmony. Any pathological condition lessening or disturbing the cerebral, and especially the cortical, nutrition, may cause derangement of memory and attention. Such is the case with the effects of alcohol, tobacco, and other narcotics. Attention is of the greatest importance to the musician. In committing anything to memory excessive fatigue should be avoided, periods of twenty minutes of effort being interspersed with periods of rest. The phenomenon of automatism after practice is of the first importance to the musical memory, the playing of pieces becoming automatic after a time. With the singer an auditory-motor bond need not be established. In the faculty of memory auditory association is the principal factor. There may be a congential absence of the musical faculty, and states in which apoplexy or paralysis play a part are frequently accompanied by loss of musical memory.—*Medical Record.*

Urotropin in Purulent Meningitis.

James F. McKernon, New York (*Annals of Otology and Layngology,* December, 1911), discusses "Urotropin in the Treatment of Purulent Meningitis." After withdrawing the cerebro-spinal fluid he introduced 50 grs. of urotropin in from 15 to 20 cc. of normal salt solution. There was a marked drop in the temperature within four hours after the injection. The streptococcus, he says, will not live in the presence of the concentrated solution of urotropin. He has used the method in three cases, and the results were sufficiently encouraging to

make him believe it is of distinct advantage in the treatment of purulent meningitis of otitic origin. In two of the cases there was a complete coma until the urotropin was injected. Several hours after the injection consciousness returned. Whether the improvement was coincident in these cases, or due to the urotropin, he could not say.—*The Lancet-Clinic.*

The Treatment of Pleural Exudates.

Drs. Karl and Silvio von Ruck, in their report from the Winyah Sanatorium, Asheville, N. C., for 1911, advocate the use of tincture of green soap in the cases of pleurisy with effusion in which the latter is not absorbed promptly. This treatment has proven valuable in many instances, not only when the exudate was serous or sero-fibrinous and of recent date, but also in all cases of fibroelastic exudates and pleural thickening.

The green soap is applied by friction over the affected side after the skin has been washed with ordinary soap and water. As a rule the application is made at bedtime, is allowed to remain over night, and is repeated daily, or less frequently, depending upon the tolerance of the skin. When hyperemia occurs as an effect of irritation this is allowed to subside before the application is repeated. In many cases the skin is tolerant enough to permit daily applications; in others marked hyperemia follows after its first use, in which event the soap must be diluted.—*The American Journal of Clinical Medicine.*

The Pupils in Phthisis.

J. L. Tuechter, Cincinnati (*Journal A. M. A.*) says that a pupillary difference as a symptom in unilateral pulmonary tuberculosis has been recognized for some time and is of some importance, deserving more attention than it has received. It is not always present, but if there is a difference it will be noted that the dilated pupil is sluggish, reacting slowly. From observation of a larger number of cases Tuechter is satisfied that a comparative dilation of one pupil signifies an enlargement of

the bronchial lymph-nodes on the corresponding side, and as such glandular involvement is usually tuberculous and occurs at a time when the lung itself does not show destructive changes, he feels that the sign is most valuable in the early diagnosis of pulmonary phthisis. It is necessary, of course, to rule out ocular conditions, which may cause the difference, and certain conditions of the thorax, such as tumor or aneurysm. Several cases illustrating that the pupillary difference not due to pathologic conditions of the eye is a valuable early sign in phthisis, with or without other symptoms, are reported. As it is due to bronchial gland involvement, it is not necessarily dependent on any condition of the lungs.—*The St. Louis Medical Review.*

Sodium Cacodylate in Erythema Multiforme.

W. Cuthbertson, of Chicago, reports a case of erythema multiforme in a woman aged 27 that had existed from childhood, occurring every fall and disappearing in the winter. Intramuscular injections of three-quarters of a grain of sodium cacodylate, given twice a week for several weeks, completely relieved the attack. Each injection was followed by relief and the disease disappeared entirely, leaving her in better condition, according to her own statement, than she had ever been in since it first occurred. From his experience in this case, Cuthbertson would recommend sodium cacodylate injections for trial in all cases of erythema, more especially in the angioneurotic type.—*The Medical Brief.*

Spinal Cord Tumors.

Flateau, who has had comparatively abundant opportunity for observing these cases, finds the operative mortality about 50 per cent, due to faulty technique, septicemia, and a group of causes little understood and probably due to operative traumatism. Much effort has been made to develop the differential diagnosis between intra and extramedullary growths. Nonne concludes that a strong phase-one reaction and an absent lymphocytosis

cannot be used to differentiate between these growths. The X-ray is of little value in the diagnosis of tumor of the cord. If, however, the spinal column is also involved by the growth, much help may be obtained. The territory embraced in the cauda equina, says Schwab, is still a region full of diagnostic pitfalls. . Not only is localization here extremely difficult, but operation is accompanied by high mortality. Further study of these cases, especially the microscopic study of such cases as come to autopsy, may add to our knowledge.—(S. I. Schwab, *Interstate Medical Journal.*)—*The Alienist and Neurologist.*

A Case of Tubercular Peritonitis: Prolongation of Life by Intra-Abdominal Administration of Oxygen.

Dr. Meeker showed a case of tubercular peritonitis which he had treated by the intra-abdominal administration of oxygen. The case was apparently cured. He also advocated its use in cases of profound shock and ascites, and said that it required from seventy-two hours to four or five days for complete absorption. Care had to be exercised in watching cases, as the abdomen became flat in from forty-eight to seventy-two hours. Collapse from its complete absorption should be guarded against by the free administration of stimulants. Dr. Bainbridge said he had been using oxygen to meet shock in abdominal surgery for the past eight years, and had treated in all about one hundred cases. He had noted marked improvement and a ready response to its use.—*Texas Medical Journal.*

Syphilitic Aortitis.

Goldscheider (*Med. Klinik,* No. 12, 1912), in "Ueber die Syphilitische Erkrankung der Aorta," contends that the condition of syphilitic aortitis or mesaortitis is much more common than generally believed, and he urges its wider recognition. Out of ninety-seven cases of syphilitic disease of the circulatory system, fifty-six cases were definitely confined to the aorta, thirty-seven cases showed a general arteriosclerosis, four myocarditis. Of the fifty-

six cases of aortic disease, twenty-one occurred without aneurysm or an insufficiency of the aortic valves, and therefore depended largely for their recognition upon certain enumerated symptoms and signs. The X-ray is a refinite aid in aneurysm and dilatation of the aorta and almost indispensable in recognizing the dilatation of the descending aorta. The Wassermann reaction has been of infinite benefit in confirming the diagnosis of syphilitic aortitis.—*The Lancet-Clinic.*

The Use of Cactus in Epilepsy.

Here is a new one about cactus, and yet not so either, for the argument was perfectly sound and had occurred to others before now. Dr. N. W. Dewees reports (*Eclectic Medical Journal* for April) five cases of epilepsy, all in men between thirty and fifty-eight years of age, who had been suffering from epilepsy for years and who showed the unfavorable mental effects of the disease. Reasoning that, if cactus would control the nerve-force in functional disturbances of the heart, it would also control functional disturbances of the brain, the doctor put his idea to the test. He says that he has proved the soundness of it many times in the treatment of patients threatened with insanity, and is confident that cactus has saved more than one of his patients a trip to the madhouse. In his judgment, cactus equalizes the nerve force in the body, promoting normal functional activity of the heart and brain. We should like reports of this use of cactus, or cactin, from our readers.—*The Am. Journal of Clinical Medicine.*

OBSTETRICAL

Menorrhagia in Young Girls.

According to *Folia Therapeutica* for October (1911), Dr. Goerl recently reported to the Nuremberg Medical Society two cases of profuse menstruation in young girls, in whom examination failed to reveal any anatomical cause for the menorrhagia, and who were rapidly and thoroughly cured by exposure of the

abdomen to the Roentgen rays. Dr. Goerl suggests that the rays act on some toxin in the circulation, a substance which is allied to the normal internal secretion of the ovary and which is responsible for normal menstruation. He is, however, unable to explain the precise way in which X-rays affect the ovarian secretion.—*The American Journal of Clinical Medicine.*

Local Anesthesia of the Uterus with Cocaine.

F. Febres advocates the performance of many operations on the cervix, both in gynecology and obstetrics, with local anesthesia by means of cocaine. The application of the cocaine is interstitial, and is made by four injections into the cervical tissues: in front, behind, and on the sides, with an amount of solution which will equal four centigrams of cocaine. In four or five minutes there is perfect local anesthesia. This method is applicable in all operations on the cervix: repair, incision of cysts, dilatation for treatment, curettage, and prolapse operations may all be done in this way. After labor the removal of adherent membranes and dilatation for rapid evacuation of the uterus may be done.—*Medical Record.*

Blood Pressure Index of Eclampsia.

H. C. Bailey (*Surg., Gyn. and Obstet.,* 1911, xiii, 505) states that the average blood pressure in the last weeks of pregnancy is 118 m.m. of Hg. Fluctuations amounting to 30 m.m. of Hg. above this need cause no alarm. Blood pressure over 150 should be thoroughly investigated at once. Blood pressure in eclampsia, with convulsions, though usually in the neighborhood of 200 m.m. of Hg., may be as low as 155 m.m. Convulsions do not occur when the blood pressure is lowered by poor resistance, as in the so-called fulminant cases or when lowered by veratrum viride or other drugs producing collapse. Treatment should be directed, not toward reducing the blood pressure, but to the treatment of the toxemia, for the rise of blood pressure may denote only the resistance of the system toward toxins. Tri-weekly blood pressure examinations, combined with regular urine examinations

for albumin and casts, offer the best safeguard against the unexpected pressure of this disease.—*New Orleans Medical and Surgical Journal.*

Direct Blood Transfusion in a Case of Ruptured Ectopic Gestation.

Dr. John O. Polak reported the case of a woman, 26 years of age, whose first symptoms referable to ectopic gestation occurred on September 6, 1911. On October 2, and again on October 13, there were symptoms of possible ruptured ectopic gestation. On November 6, on account of localized pain in the right lower quadrant of the abdomen she was operated upon by Dr. Polak and a large hematocele was revealed and evacuated. A three months' fetus was found floating free among the intestines in the right renal region. The placenta was attached in the right tube. After securing the points of hemorrhage the abdomen was closed. About eight hours after the operation there were symptoms of secondary hemorrhage and the abdomen was reopened but no bleeding point was found. The abdominal cavity was filled with free serum. While the incision was being closed Dr. Brinsmale exposed the right saphenous vein, and Dr. Bristow inserted the right radial artery of her husband into the vein, completing an anastomosis. The transfusion of blood thus made possible was continued for one hour. The effect was magical; the pulse slowed and became fuller, the lips became rosy, and the hemoglobin index rapidly increased. The operation was followed by a perfect recovery.

The points of interest illustrated in the case are first, that hydremic patients stand shock badly and are made worse by the intravenous use of saline solution. Second, that it is difficult to differentiate shock from hemorrhage in patients with low red cell resistance. Third, the marked benefit of direct blood transfusion. —*Long Island Medical Journal.*

Adrenalin in Hyperemesis Gravidarum.

Robinson recently presented to the Academie des Sciences a very remarkable contribution to the study of the relationship be-

tween the suprarenals and the gravid state, also their use in hyperemesis gravidarum.

His article was based upon two very interesting cases. One patient vomited so severely that she could not take any kind of food. Ten drops of 1-100 solution of adrenalin was administered. The first day the vomiting ceased and the patient began to eat. She stopped the drug after three weeks and the vomiting started afresh, but returning to the adrenalin it ceased. After continuing this treatment for several months she was delivered of a healthy child. The second case was almost same as the first.

These two cases show that there is an intimate relationship between the adrenals and the genital glands. The pigmentation of the skin, the rebellious vomiting and the lassitude of Addison's disease is often met with in certain cases of pregnancy to which we refer. The author wishes to interpret these manifestations accordingly: the products of the adrenals and the genital glands neutralize each other in the normal state, but when one of the two products becomes exceedingly active, the other becomes fatally reduced unless substituted by the vicarious organ.

We know the beneficial effect that adrenalin has upon osteomalacia, which is likewise slightly relieved by removal of the ovaries. There is no doubt a synergistic action between the two functions.—*La Tribue Medicale.*

Pituitary Extract in Obstetrics.

After using intramuscular injections of pituitary extract in a large number of cases the author concludes that the best time to administer the drug, in the first stage of labor, is when the os is a little less than the size of the palm, in primiparæ, and when it will just admit two fingers, in multiparæ. If given at a time when pains have not yet appeared its effects are but temporary and ineffective. But if given later, its action, which begins to show itself in three minutes, induces powerful, frequently repeated uterine contractions for about ten minutes; during this time the uterus remains in partial contraction in the intervals between pains. Later, the effect gradually diminishes, disappearing in an hour. The power of the contractions induced by full doses

is shown in that the fetal heart rate may be more or less markedly reduced.

Employed in the period of expulsion of the fetus, pituitary extract, according to the author, will in many instances render the application of forceps unnecessary. Its use is clearly indicated in secondary uterine inertia and in cases where, owing to undue enlargement of the uterus because of hydramnios or twin pregnancy, the pains are ineffective. In febrile states it may also be employed. Where complications are expected after the birth of the child, an injection of pituitary extract a few minutes before the end of the second stage is to be recommended. On the other hand, if the birth of the child does not take place until about an hour after the injection, a possible hemorrhage is to be feared, and the patient must be closely watched..—F. Jaeger (Müunchener medizinische Wochenschrift, February 6, 1912).

Another observer writes concerning the effect of pituitary preparations (pituitrin in particular) in the early months of pregnancy, when, in the treatment of cases of abortion, local intervention in the form of curettage is considered inadvisable, and a remedy is desired which will limit absorption by firmly contracting the uterine wall and tend to expel the fetal remains. He found that, because of the less irritability of the uterus early in pregnancy, the results of pituitrin injection were much inferior to those obtained later, and were no more certain than those of ergot or of hot and cold vaginal douching.—L. Hell (Münchener medizinische Wochenshrift, December 12, 1911).

Editorial

PUBLISHER'S NOTICE—The Journal is published in monthly numbers of 48 pages at $1.00 a year, to be always paid in advance.

All bills for advertisements to be paid quarterly, after the first insertion of the quarter.

Business communications, remittances by mail. either by money order, draft, or registered letter, should be addressed to the Business manager, C. S. Briggs, M. D. corner Summer and Union Streets, Nashville, Tenn.

All communications for the Journal, books for review, exchanges, etc., should be addressed to the Editor.

SUICIDE.

In this era of preventive medicine in which so much has been accomplished in the fight against disease and death, some steps should be taken to prevent death by suicide, and the medical profession, especially the neurologists, should lead the fight. The neurotic type can be found throughout the civilized world, but nowhere in such numbers as in America, where everybody leads the strenuous life. Some seem to feel no evil effects from the constant strain, but most of us do, and even though we ourselves escape, our descendants are apt to be streaked with some neurotic stripes. Suicides are usually neurotic and unbalanced, and so can not view the world like a normal man. Since they are neurotic they are impressionable, and everything possible should be done to prevent wrong impressions developing in fertile soil.

The newspapers, with their vivid and minute descriptions of suicides are responsible for many of the annual number of suicides in America, and for that matter throughout the world. Suicide is a crime, and like other crimes it should be recorded only and not be made the leading article of the day's news. All crimes would decrease in number, and especially suicides, were it the custom to devote only a few necessary lines to the facts. All descriptions of the criminal should be confined to his name and occupation. Suppositions as to cause, letters left behind, his actions immediately preceding death, etc., often make the suicide a martyr or hero, and we all know that he is seldom either. These yellow journal descriptions appeal to the minds of other neurotics, and so they, too, commit suicide. Why such is the case nobody knows, but it is a fact that crimes in one part of a country are

followed by similar crimes in distant sections of the same country, sometimes even in foreign lands. Although the automobile bandits in Paris finally came to grief, yet already they have had their imitators. Some of these imitators have been nothing more than children. The negro fiend usually pays for his crime almost as soon as it's committed, and yet these crimes are epidemic in certain sections.

Freedom of the press is something we all desire, but when this freedom destroys the homes and happiness of others it should be checked, and it will be checked. The question is, When?—W. T. B.

John A. Witherspoon, M.D.

At the annual meeting of the American Medical Association in the early part of this month, Dr. John A. Witherspoon, of Nashville, Tenn., was chosen president. We wish to congratulate Dr. Witherspoon for winning this honor, and at the same time the American Medical Association for choosing one so eminently qualified for this honorable position. Nashville has given four presidents to this association: Drs. Paul F. Eve, W. K. Bowling, W. T. Briggs and John A. Witherspoon. This is a large percentage for a city the size of ours, and we can not help feeling proud of the local profession which proves itself worthy by producing such men as these. We trust that the future will produce others from Nashville qualified for this honor, but feel sure that none will grace the office better than those who have gone before, and the present incumbent.

Lister's Legacy.

The legacy to the human race of the beneficent discovery of antiseptic surgery were legacy enough, a legacy which would never cease to benefit the legatees and go on accruing in value till time is no more. Yet it is fortunate that Lister was through all his life able to make shillings subservient to science illings. You have all heard of John Hunter's exclamation when called from research to the realities of life: "I suppose I must go and earn this d—d guinea, or I shall be sure to want it tomorrow."

Had Lister been interrupted under the same need which Hunter was we can not imagine him using the same forceful language, yet fortune had provided kindly for Lister and practice was secondary to science in his case. It is a question often whether want stimulates scientific investigation or not. Probably it depends more on the man than his money, though money is a valuable adjunct and becoming more so. Lister's whole life was one of kindness and consideration. What else could you expect of the man who said that kindness of heart is the first requisite for a surgeon. It is not therefore surprising that Lister left the bulk of his estate, 65,000 pounds, for the benefit of mankind and the furtherance of research directed towards the discovery of the means of the prevention and the cure of disease. His career was consistent from first to last, and the disposal of his estate shows that his devotion to that greatest of all human endeavor was strong—even in death. Always a modest, kind and considerate gentleman, who loved his fellowmen. Such titles as Professor, Sir and Lord seemed so superfluous to Lister.—E. S. McK.

State Fair.

Attention is called to the advertisement of the State Fair in another part of this paper.

The fair this year will be State-wide in every particular, and educational in every feature.

$30,000 will be given in premiums for Live Stock, Field Products, Garden Products, Orchard Products, Dairy Products, etc.

Everything well cared for in liberal premiums.

Boys' Corn Clubs and Girls' Tomato Clubs have been provided for in the catalogue, which is being distributed free.

All you have to do is to write for one.

A free trip for some boy from every County in the State. Write for particulars. You may be the boy selected, and you will be given a free trip to the fair, and can remain for one week without having to spend a cent for railroad fare, board, and other expenses necessary for such a trip.

The amusement features will be high-class: Fireworks every night. Night horse show. Races every afternoon. Free acts

afternoons and evenings. Three brass bands in concerts three times daily. Best of all, the railroads will grant low rates to see the big fair.

Graduation Exercises.

The annual graduation exercises of the Vanderbilt Medical School were held Tuesday evening, May 21, in College Hall on the west campus. There were sixty-six graduates, which is the largest number for some years. Dr. M. C. McGannon delivered the faculty address.

Dr. Dudley, Dean of the Medical Department, awarded the scholarships and the Founder's Medal. William Bell Goddard, Kentucky, was the winner of the scholarship in the first year class; Raymond Myers Evans, Kentucky, winner in second year class; Joe Davis Applewhite, won it for the third year class, and Dr. Andy Anderson Eggstein, Tennessee, won the Founder's Medal.

About half of the class received hospital appointments in the different hospitals throughout the country.

Reviews and Book Notices

Progressive Medicine (Awarded Grand Prize, Paris Exposition, 1909).—A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia; Physician to the Jefferson Medical College Hospital; One Time Clinical Professor of Diseases of Children in the University of Pennsylvania; Member of the Association of American Physicians, Etc. Assisted by Leighton F. Appleman, M.D., Instructor in Therapeutics, Jefferson College, Philadelphia; Ophthalmologist to the Frederick Douglass Memorial Hospital; Instructor in Ophthalmology, Philadelphian Polyclinic Hospital and College for Graduates in Medicine. Volume II. June, 1912. Hernia—Surgery of the Abdomen, Exclusive of Hernia—Gynecology—Diseases of the Blood. Diathetic and Metabolic Diseases. Diseases of the Spleen, Thyroid Gland, Nutrition, and the Lymphatic System—Ophthalmology. Lea & Febiger, Philadelphia and New York, 1912.

Our thanks are due the publishers for the current number (June), of this excellent quarterly publication. It is an unusually

interesting number and compares favorably in all respects with the foregoing issues of this valuable serial. The contents of this number are as follows: Hernia, by William B. Coley, M.D., New York City; Surgery of the Abdomen, Exclusive of Hernia, by John C. A. Gerster, M.D., New York City; Gynecology, by John G. Clark, Philadelphia, Pa.; Diseases of the Blood, Diathetic and Metabolic Diseases, Diseases of the Thyroid Gland, Nutrition and the Lymphatic System, by Alfred Stengel, M.D., Philadelphia, Pa.; Ophthalmology, by Edward Jackson, M.D., Denver, Colo.; Index. It may be seen from this table of contents and the list of distinguished authors that a variety of interesting subjects is presented, and that the very latest views upon these subjects are given in the most interesting way. The paper upon Hernia is especially valuable, written by a man of world wide reputation for his experience in this particular disease. In commending this excellent quarterly to our readers we urge upon every physician to subscribe to the work, assuring him that he can get knowledge in this way what he could only require by laborious research through current medical literature. The work of these contributors insures a true harvest in which the chaff has been removed and the true grain remains.

Publisher's Department

The Prevention of Dysmenorrhea.

How can we prevent dysmenorrhea? It can be done by keeping the patient under morphine, but this is a barbarous solution of an important problem. It in fact does not solve it. Morphine is inadmissible and improper in these cases. It produces derangement of the secretions and tends to establish a drug habit that will make life a burden. I have long employed a remedy that not only relieves the pain, but produces no habit, and is not dangerous. I refer to Dioviburnia. It is a most valuable uterine tonic, antispasmotic and adoyne of exceptional worth. I rely upon this remedy to prevent dysmenorrhea, which, as Professor Davenport truly says, is seen in almost all, if not all, women. I have my patients, who suffer with dysmenorrhea to take Dioviburnia, beginning

two days before menstruation is due and persist in it until the period has passed. I give it in doses of one to two teaspoonfuls every three hours throughout this time. When this direction is followed I have found that my patients go through the period without pain. The adoption of this treatment I may say, also, has brought me many grateful compliments.

Where the patient is very nervous, having the tendency to hysteria, neuroses or unterine congestion, I administer Neurosine one part, in combination with two parts of Dioviburnia, which always gives relief.—L. G. Boyd, M.D.

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"The diarrhoea is controlled by irrigation of the gut. The rectum and gut are washed out in those cases in which the diarrhoea is not only persistent, but progressive. The object in washing out the lower bowel in any form of acute gastro-enteritis is twofold: (a) To remove any residue of feces that may have collected in the lower bowel and rectum, and to stimulate peristalsis and thereby favor evacuation from above. (b) To stimulate the heart and add to the body an amount of normal solution to compensate for the drain caused by the diarrhoea.

"The rectal enemata are given under a pressure obtained by an elevation of at at most, two feet from the body. A temperature of 107° to 110°F. (40.5° to 43.3°C.) is the best and most stimulating in these cases. Fully a quart of water is thrown into the rectum in half pint portions. As the half pint flows in, the funnel of the rectal tube is disconnected and the contents of the bowel is allowed to escape. Another portion is then allowed to flow into the bowel. The water will sometimes escape alongside of the tube. This is rather a favorable sign, being significant of the contractile powers of the gut and abdominal walls. Only two enemata daily are necessary, even in severe cases of acute gastro-enteritis. As the diarrhoea and symptoms subside, we reduce the number of enemata to one."

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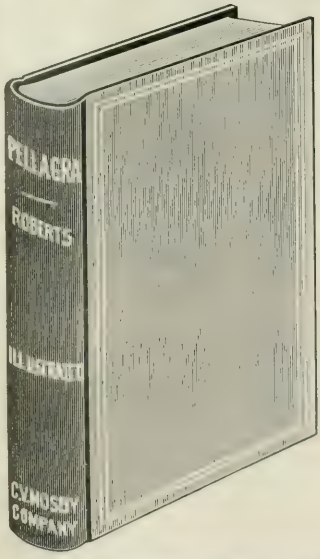

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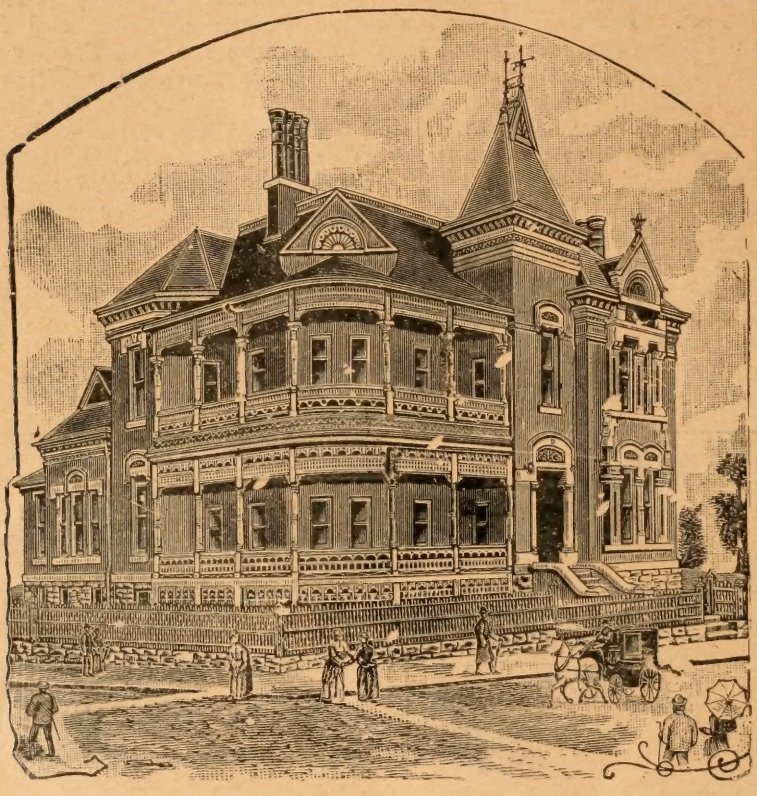

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